Billing Information

Claim Submission

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided.

All claims, whether electronic or paper, are subject to the same Medicaid processing and legal requirements.

Electronic Billing

Prenatal care coordination (PNCC) providers are encouraged to submit claims electronically. Electronic claims submission:

- Reduces processing time.
- Eliminates manual handling of claims.
- Reduces both billing and processing errors.

Wisconsin Medicaid provides free software for billing electronically. For more information on electronic billing:

- Refer to the Claims Submission section of the All-Provider Handbook.
- Contact the Electronic Media Claims (EMC) Department at (608) 221-4746. Ask to speak with an EMC coordinator.

If you are currently using the free software and have technical questions, please contact Wisconsin Medicaid's software customer service at (800) 822-8050.

Paper Claim Submission

Providers submitting paper claims must use the HCFA 1500 claim form (dated 12/90). Appendices 2 and 3 of this handbook contain completed samples of HCFA 1500 claim forms for PNCC services. Refer to Appendix 1 of this handbook for HCFA 1500 claim form completion instructions.

Wisconsin Medicaid denies claims for PNCC services submitted on any paper claim form other than the HCFA 1500 claim form.

Wisconsin Medicaid does not provide the HCFA 1500 claim form. Providers may obtain these forms from any vendor that sells federal forms.

Where to Send Your Claims

Mail completed HCFA 1500 claim forms for reimbursement to the following address:

Wisconsin Medicaid
Claims and Adjustments Unit
6406 Bridge Road
Madison, WI 53784-0002

Claim Submission Deadline

Wisconsin Medicaid must receive properly completed claims within 365 days from the date the service was provided. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the 365-day claim submission deadline and requirements for submission to Late Billing Appeals can be found in the Claims Submission section of the All-Provider Handbook. Providers may access the handbook online at *www.dhfs.state.wi.us/medicaid/*.

Billed Amounts

Providers are required to bill their usual and customary charge for the service performed. The usual and customary charge is the provider's charge for providing the same service to persons not entitled to Wisconsin Medicaid benefits. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

Providers may not discriminate against Wisconsin Medicaid recipients by charging Medicaid a higher fee for the same service than that charged to a private-pay patient. For providers who have not established usual and customary charges, the charge should be reasonably related to the provider's cost to provide the service.

Reimbursement

Providers are reimbursed at the lesser of their usual and customary charge and the maximum allowable fee established by the Department of Health and Family Services (DHFS).

The maximum allowable fee is the amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. Refer to Appendix 19 of this handbook for a copy of the Wisconsin Medicaid maximum allowable fee schedule for PNCC services.

To obtain subsequent maximum allowable fee schedules, or to ensure you have the most recent fee schedule, you may:

- Purchase a paper schedule by using the order form located in the Claims Submission section of the All-Provider Handbook or by writing to:

  Wisconsin Medicaid
  Provider Maintenance
  6406 Bridge Road
  Madison, WI 53784-0006

- Download an electronic version from Wisconsin Medicaid's Web site using directions located in the Claims Submission section of the All-Provider Handbook. Wisconsin Medicaid's Web site is located at *www.dhfs.state.wi.us/medicaid/*.

Procedure Codes

All claims submitted to Wisconsin Medicaid must include procedure codes. Allowable HCFA Common Procedure Coding System (HCPCS) codes for PNCC services are listed in the shaded box on this page and in Appendix 4 of this handbook. Claims or adjustments received without the appropriate HCPCS codes are denied.

Diagnosis Codes

Claims submitted for PNCC services must include either diagnosis code V23.9 (unspecified high-risk pregnancy) or V22.2 (regular pregnancy).

Use diagnosis code:

- V23.9 when billing on behalf of recipients who score 40 points or more on the Pregnancy Questionnaire (i.e., those who are determined eligible to receive services).

It is vital that providers use the correct procedure codes, diagnosis codes, and modifiers when billing for PNCC services:

Procedure Codes

- W7090 Risk Assessment.
- W7091 Initial Care Plan Development.
- W7092 Ongoing Care Coordination and Monitoring.
- W7093 Health Education/Nutrition Counseling - Individual.
- W7094 Health Education/Nutrition Counseling - Group.

Diagnosis Codes

- V23.9 Unspecified high-risk pregnancy.
- V22.2 Regular pregnancy.

Use V23.9 when billing for:

- Recipients who score 40 or more points on the Pregnancy Questionnaire (initial risk assessment).
- Procedure codes W7091, W7092, W7093, or W7094.

Use V22.2 when billing for:

- Recipients who score fewer than 40 points on the Pregnancy Questionnaire (initial risk assessment).

Remember to use a modifier to indicate the recipient's risk assessment score when billing for procedure code W7090. Use the modifier "SP" with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. Please refer to Appendix 4 of this handbook for the appropriate modifiers.

- V23.9 when billing procedure codes W7091-W7094.
- V22.2 when billing on behalf of recipients who score fewer than 40 points on the Pregnancy Questionnaire (i.e., those who are assessed but determined ineligible to receive services).

Use the modifier "SP" with all prenatal care coordination procedure codes for subsequent pregnancies within 185 days of previous pregnancies.

Wisconsin Medicaid will deny claims if providers use other diagnosis codes when billing for PNCC services.

Time Units

When billing for risk assessment (W7090) and initial care plan development (W7091), always bill for one unit.

Round time units to the nearest tenth of an hour when billing for ongoing care coordination and monitoring (W7092) and health and nutritional counseling (W7093 and W7094).

Refer to Appendix 6 of this handbook for more information on rounding guidelines for PNCC services.

Modifiers

Claims submitted for risk assessments (procedure code W7090) must include a modifier indicating the recipient's total risk assessment score.

Allowable modifiers are listed in Appendix 4 of this handbook. Claims for risk assessments that do not include the appropriate modifier are denied.

Modifier for Second Pregnancy

In some circumstances, a confirmed subsequent pregnancy may require the provision of PNCC services within 185 days of the provision of services for an earlier pregnancy. Use the modifier "SP" with a PNCC procedure code if the date of service falls within 185 days of the date of service for the same procedure code billed for an earlier pregnancy. For instance, use the modifier "SP" when billing for the initial care plan development (W7091) for a recipient's subsequent pregnancy if the date of service falls within 185 days from the date the same service was billed for a previous pregnancy.

Use the modifier "SP" with all PNCC procedure codes for subsequent pregnancies within 185 days of previous pregnancies. When billing for the second risk assessment, the modifier representing the risk assessment score must also be used.

Wisconsin Medicaid will deny claims for services provided within 185 days from the previous dates of service if the claims are not accompanied by the "SP" modifier.

Follow-Up to Claim Submission

The provider is responsible for initiating follow-up procedures on claims submitted to Wisconsin Medicaid. Processed claims appear on the Remittance and Status (R/S) Report either as paid, pending, or denied. Wisconsin Medicaid will take no further action on a denied claim until the provider corrects the information and resubmits the claim for processing.

If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to Wisconsin Medicaid. Refer to the Claims Submission section of the All-Provider Handbook for more information on filing Adjustment Request Forms.

To be reimbursed for additional ongoing care coordination time that may have been omitted from the original claim, providers are required to file an Adjustment Request Form.